STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155773	B. WIN			01/31/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	I .	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ICDOWELL RD		
TEDDAC	E AT SOLARBRON	JITUE			SVILLE, IN 47712		
TERRAC	E AT SOLARBRON	N IIIE		EVANS	SVILLE, IN 477 12		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
]			l				Į
	This visit was for th	ne Investigation of Complaint	F00	00	Preparationand Execution of this		
	IN00102912.				Response and Plan of Correction	do	
					notconstitute an admission or		
	_	2912 - Substantiated.			agreement by the provider of the		
		encies related to the allegations			truth of the facts alleged or		
	are cited at F309 an	d F327.			conclusion set forth in the statem	ent	
					ofdeficiencies. This Plan of		
	Survey dates: Janua	ary 30 and 31, 2012			Correction is prepared and/or		
					executedsolely because it is requ	ired	
	Facility number: 01				by the provisions of federal and		
	Provider number: 155773				statelaw.		
	AIM number: N/A				CredibleAllegation of Correction	and_	
	_				Compliance:		
	Survey team:	22.7			Forpurposes of any allegation tha	at	
	Anne Marie Crays I	RN			The Terrace at Solarbron is not		
	0 1 1				incompliance with the regulation	s as	
	Census bed type:				set forth in this statement	.4	
	SNF: 32 Residential: 35				ofdeficiencies, this Plan of correct	Stion	
	Total: 67				constitutes the facility'scredible allegation of correction and		
	10ta1. 07				compliance.		
	Census payor type:				comphanice.		
	Medicare: 19						
	Other: 48						
	Total: 67						
	Sample: 4						
	These deficiencies a	also reflect state findings cited					
	in accordance with						
	Quality review com	pleted 2/6/12 by Jennie					
	Bartelt, RN.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

010930

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 02/24/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773 NAME OF PROVIDER OR SUPPLIER			A. BUILDING B. WING STREET	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 01/31/2012
	PROVIDER OR SUPPLIE E AT SOLARBROI		1701 M	ICDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NNEL11

Facility ID: 010930

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155773	B. WIN			01/31/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
TEDDAG		LTUE			CDOWELL RD		
TERRAC	E AT SOLARBRON	NIME	EVANS		WILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)		DEFICIENCY)	-	DATE
F0309	Each resident mus	st receive and the facility					
SS=G	must provide the r	necessary care and					
		or maintain the highest					
	practicable physical, mental, and						
	• •	being, in accordance with					
		e assessment and plan of					
	care.	1 1 1 1 1 1 1 1			 	l	
	Based on interview and record review, the facility failed to ensure a resident with change in		F03	09	F309 Thecorrective action	L -	02/21/2012
		C			taken for those residents to l		
		sed for distention of the			affected by thealleged deficient practice include: Resident "A"		
	_	nd symptoms of dehydration. ce affected 1 of 4 residents			longer resides at the facility as		
	-	ation and incontinence in a			indicated in the 2567. RN#1 h		
		ent A) Resident A was			been terminated.	as	
	* `	ospital emergency room and			Otherresidents having the		
		hospital. In the emergency			potential to be affected by th	e	
		ine was drained from the			allegeddeficient practice hav		
		Diagnoses at the time of			been identified by: All resider		
		acute urinary retention,			have been assessed related to)	
	hyponatremia, and h	-			hydration status and risk for		
	J	J.F			dehydrationwith appropriate		
	Findings include:				interventions implemented bas	sed	
	C				on the assessment.		
	On 1/30/12 at 3:30 I	P.M., the clinical record of			Themeasure or systemic		
	Resident A was revi	iewed. The resident was			changes that have been put		
	admitted to the facil	ity on 11/9/11 with diagnoses			into place to ensurethat the		
	including, but not lin	mited to left femur fracture			alleged deficient practice do not recur include: All resident		
	and urinary tract inf	ection.			have been assessed relating to		
					their hydration status with		
	Nurses Notes includ	led the following notations:			appropriate interventions		
					implemented based on the		
		.: "Admitted to [room			assessment. The Hydration		
		asionally] forgetfulIncont			StatusAssessment will be		
	[incontinent] of blac				completed upon admission,		
		st for set up of oral care,			re-admission from thehospital,		
	meals. Assist [two]	transier"			quarterly, and upon change in		
	A "IIIviduation Ctot	A acceptant !! dat- 1 11/0/11			condition. Residents identified		
		s Assessment," dated 11/9/11, nt had decreased food & fluid			"at high risk" upon admission v	VIII	
		nt nad decreased food & fiuld nucous membranes, and			be placed on 3-day Intake &	ant	
	-				Output monitoring. If the reside		
	runctional impairme	ents. The assessment indicated			is not meeting recommended f	iula	

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Event ID: NNEL11

Facility ID: 010930

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155773	A. BUII			01/31/	2012
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					ICDOWELL RD		
TERRAC	E AT SOLARBRO	N THE		EVANS	SVILLE, IN 47712		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	the resident was no	t on a diuretic, had no renal			intake goals, the resident will		
	impairment or eden	na, was not lethargic, had no			remain on Intake &		
	abnormal lab result	s of electrolyte imbalance, and			Outputmonitoring until the inta	ıke	
	had no increased flu	uid needs. The resident's total			is adequate according to the		
	score on the assessi	ment was 3 ["If 8 or above, MD			residents physician. All reside	nts	
	to be notified & hy	dration management			identified as having a Urinary		
	interventions follow	ved"].			TractInfection will also be place		
					on Intake & Output monitoring		
	An Interdisciplinar	y Care Plan, dated 11/9/11,			until the infection has been		
	indicated, "Residen	at diagnosed with UTI [urinary			resolved. To		
		pproaches included: "Offer and			improvecommunication, the "a		
	encourage intake of				high risk" residents's status wi		
	J				be reviewed at each shift char		
	An additional Inter	disciplinary Care Plan, dated			in nursing personnel. Included		
		"Resident has potential for			the information is the resident	's	
		ed to urinary elimination due to			Intake & Output status. A		
		e, overactive bladder."			daily(Monday through Friday)	_	
		ed: "Monitor for complications			status report on "at risk reside	nts"	
		of dysuria [difficulty			willbe given to the Director of		
	urinating], frequence				Nursing or designee for review	V	
		adequate fluid intake"			and recommendations and/or		
	outputEncourage	adequate fluid fluide			interventions. Nursing personi	nel	
	Nurses Notes contin	nued:			have been in-serviced on	. 1	
	runses motes contin	nucu.			providing accurate and comple		
	11/10/11 at 2:00 D	M.: "Res [resident] will			assessmentswhich are to inclu		
		questions, takes sips			conducting bladder palpitation		
		assist. Required to be fed for			and implementing plans of car		
		tesIncontinent of urine x 4"			based on information from the	;	
	incais, takes iew ui	icsmcontinent of titlie x 4			assessment. Nursing personnelhave been in-service	ed l	
	11/11/11 at 6:20 A	M: " Incontinent of bladder			on the Hydration Policy and th		
		M.: "Incontinent of bladder, ing upon urination. Cont			new forms which include the		
		ing upon urination. Cont [antibiotic] for UTI [urinary]			Hydration Status Assessment	and	
		s does c/o [complain of]			Intake & Output Shift Monitori		
	-	s does c/o [compiain of]			Tool/Binder. <i>Thecorrective</i>	-	
	frequency"				actions to monitor	•	
	11/11/11 of 1-00 B	M · "Call out to Inoma of			performance to assure		
		M.: "Call out to [name of			compliancethrough quality		
	physician] office r/s				assurance are: The Director		
		tient] noted to be lethargic			ofNursing or designee will ens	sure	
		NO's [new orders] @ this			that the new monitoring tools	,	
	time."				arebeing utilized. A Performa	nce	
					a sporing atmized. At a chomia		

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Event ID: NNEL11

Facility ID: 010930

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPLETED
		155773		LDING		01/31/2012
			B. WIN			
NAME OF P	ROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e		1	ADDRESS, CITY, STATE, ZIP CODE	
TEDD 4.0	o				CDOWELL RD	
TERRAC	E AT SOLARBRON	NIHE		EVANS	VILLE, IN 47712	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	11/11/11 at 1:05 P.M	M.: "Remains on ATB for			Improvement Tool has been	
	UTITaking fluids	well [with] encouragement et			established that will randomly	
		sic] pt while eating. Continues		review 5 residents to ensure that	I	
	to c/o lethargy et weakness"				services are being provided in	
					accordance with the physician	
	11/11/11 at 5:00 P.N	M.: "Pt c/o nausea earlier"			orders, the written plan of care	;
	11/10/11 : 0 00 = -	6 H D : 1777 3			relating to areas of "high risk" identified by assessments, and	,
	11/12/11 at 2:00 P.M.: "Remains on ATB for				adherence tothe Hydration Po	
	•	urinary frequency, no pain or			This tool will be completed by	
	burning with urinati	OII			Director of Nursing, or designe	
	11/1 2 /11 at 6·20 D N	M.: "Taking fluids [without]			weekly X3, monthly X3, then	·
		ged to eat when offered. Pt			quarterly X3. Any issues will b	e
	takes bites only."	ed to cat when offered. I t			immediately corrected. The	
	takes offes offiy.				completed audits will bereview	
	11/13/11 at 5:00 A	M.: "ATB for UTIfluids			at the routinely scheduled Qua	ality
	encouraged [and] w				Assurance Meeting with	
					additional recommendations a	S
	11/14/11 at 2:00 P.M	M.: "N.O. received for			needed for one year.	
	Levaquin [antibiotion	e] et Lasix [diuretic]Res c/o				
	some nausea"					
		M.: "Offered water at this time,				
		ouragement. Denied need to				
	use bathroom"					
		Care Plan, dated 11/14/11,				
		t at risk for fluid volume deficit				
		retic Use." Approaches				
		and report to physician signs & AbydrationPhysical signs &				
		ration. Discuss with resident				
		fluid intake. Encourage fluid				
		veen meals. Observe for S/S				
		as] of dehydration & report to				
		s, Dry mucous membranes,				
		rurgor, Dark urine, Poor fluid				
	intake/thirstIncrea					
	A Nutrition Risk As	ssessment, dated 11/15/11,				
	indicated, "Diet or	rder, Mech [mechanical] soft				

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Event ID: NNEL11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DING	00	COMPLETED
		155773	A. BUILDING		01/31/2012
			B. WING	ADDRESS CITY STATE ZID CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
				ICDOWELL RD	
TERRAC	E AT SOLARBRO	NIHE	EVANS	SVILLE, IN 47712	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	[with] gr [ground]	meatEating ability: Needs			
	Tray Setup, Partial	Assist/CueingAverage fluid			
	intake fairNutritional Needs EstimationFluid Needs (mL): 1590 mL"				
		rdisciplinary Care Plan, dated			
		d, "Potential for alteration in			
	_	osis: [Left] femur fx [fracture]			
		[and] pneumonia." Approaches			
	included: "Monito	r food/fluid intake."			
	Nurses Notes cont	inuad:			
	Nuises Notes cont	muea.			
	 11/15/11 at 4:30 Δ	M.: "Refused to get up to the			
		ed bedpan x 2Continues on			
	ATB for UTI"	ed bedpan A 2Continues on			
	1112 101 0 11				
	11/16/11 at 4:15 A	M.: "Has been Inc x 1 this			
		et up [and] go to Bathroom. Has			
	_	Has drank plenty of fluids"			
	A Physical Therap	y progress note, dated 11/17/11			
	and untimed, indic	ated, "Pt very lethargic today.			
		eakfast per daughter. Pt had to			
		hour napPt could hardly keep			
		eelchair]Pt tol [tolerance] very			
	poor today. RN no	tified."			
		e physician, dated 11/17/11 and			
	· ·	, "Pt has an order for Flexeril 5			
		xer]but this is very sedating. Pt			
		leg syndrome symptoms @			
		nable to sleep. Could we maybe			
	try Requip?"				
	An additional note	faxed to the physician, dated			
		ned, indicated, "[Resident A] is			
		for a poss [possible] dx			
		umonia. She has an occ			
		cough, productive @ x's			
	-	nk a PRN [as needed] Albuterol			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155773	B. WING	G		01/31/	/2012
NAME OF I	PROVIDER OR SUPPLIE	P	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	ROVIDER OR SOLITEE	K		1701 M	CDOWELL RD		
TERRAC	E AT SOLARBROI	N THE		EVANS'	VILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	[nebulizer] tx [treat	tment] would help her"					
	Δ dietician note fax	xed to the physician, dated					
		ned, indicated, "Resident was					
		and] made the following					
		Residents [sic] wt. this week is					
		7 lbs x 1 wk). PO [by mouth]					
	,	ir. Would like to add 90 cc Med					
		nes daily] as supplement."					
	Nurses Notes conti	nued:					
	11/17/11 at 1:30 P.	M.: "Taking fluids well					
	[with] encourageme	-					
	11/18/11 at 4:00 P.	M.: "Pt remains weak. Not					
	taking much nutriti	on. Encouraging med pass and					
	magic cup when do	es not eatIncont of Bowel					
	[and] bladder. Wea	rs briefs"					
	11/18/11 at 7:30 P.	M.: "Called to pt room. Had					
		coolAbd [abdomen] distended,					
		umbilicus area. Nontender to					
	palpation, done ver	ry gently. Abd mass firm to					
	touchNew order i	need to transport to [name of					
	hospital] ER [emer	gency room] for evaluation if					
	family wishes."						
	The resident was tr	ansferred to the hospital on					
	11/18/11 at 7:50 P.	-					
		ncy room note, dated 11/18/11					
		cated, "The patient was					
		fter arrivalShe was noted to					
	_	abdominal pelvic mass which					
		lder distention initially on					
		very weak and dehydrated in					
		y oropharynx findingsShe had					
		aced and drained almost over					
		She does have a panic values					
	sodium level of 118	8. She was started on some IV					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155773	B. WIN	G		01/31/	2012
NAME OF P	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP CODE		
TEDDAG		I TUE			CDOWELL RD		
	E AT SOLARBRON				VILLE, IN 47712		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110		ssion, Abdominal pain, acute	+	0			DITE
		Itered mental status,					
		sodium], hypokalemia [low					
	potassium]"						
	A facility Food Inta	ke Record, dated November					
	I	resident consumed the					
	following amounts of fluid: 11/10: 520 cc, 11/11: 530 cc, 11/12: 380 cc, 11/13: 480 cc, 11/14: 660						
	cc, 11/15: 720 cc, 1 11/18: 180 cc.	1/16: 720 cc, 11/17: 580 cc,					
	11/10. 100 cc.						
	A facility Resident	Care Record, dated November					
		resident was incontinent of					
	bladder 7 times on 11/16, 6 times on 11/17, and 8						
	times on 11/18. The amount of the urine	e record did not specify the					
	amount of the urine						
	On 1/31/12 at 9:20	A.M., during interview with					
		ed she was the nurse who was					
	_	1 and transferred Resident A					
		# 1 indicated she did not think s felt like a distended bladder.					
		elt like "something else must					
		." RN # 1 indicated she knew					
	the resident had bee	en having wet briefs, and was					
		a UTI. RN # 1 indicated she					
		t had a previous history of					
	"bladder problems.'						
	On 1/31/12 at 10:30	A.M., during interview with					
	the Administrator a	nd MDS Coordinator, they					
		of Resident A stayed with the					
		and frequently would not let					
		ent to feed her or give her strator indicated the nurse who					
		lent to the hospital was not a					
		lder more experienced nurse.					
	This federal tag rela	ates to Complaint IN00102912.					
	I		- 1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773			(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 31/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP C CDOWELL RD	CODE	
TERRAC	E AT SOLARBRON	ITHE		VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	3.1-37(a)					
ı						

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PRINTED: 02/24/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMF 01/3	COMPLETED 01/31/2012	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CC CDOWELL RD	DDE	
TERRAC	E AT SOLARBRON	I THE		VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE

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Event ID: NNEL11

Facility ID: 010930

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X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155773 01/31/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 MCDOWELL RD TERRACE AT SOLARBRON THE **EVANSVILLE. IN 47712** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE F0327 The facility must provide each resident with SS=G sufficient fluid intake to maintain proper hydration and health. Based on observation, interview, and record F0327 F327 It is the practice of the 02/21/2012 review, the facility failed to ensure a resident Terrace at solarbron to ensure that each resident is provided received sufficient fluid intake to prevent sufficient fluid intake to maintain dehydration, resulting in hospitalization for proper hydration. Thecorrection dehydration, for 1 of 4 residents sampled for actions taken for those hydration, in a sample of 4. Resident A residents found to be affected bythe alleged deficient practice Findings include: include: Resident "A" has been discharged from the facility as On 1/30/12 at 1:25 P.M., during the initial tour indicated in the 2567. Nurse #1 with the MDS [Minimum Data Set] Coordinator, has been terminated. water pitchers or bottles were not observed at the Otherresidents that have the bedside of dependent residents. potential to be affected by the allegeddeficient practice have On 1/30/12 at 3:30 P.M., the clinical record of been identified by: All resident Resident A was reviewed. The resident was have been assessed related to admitted to the facility on 11/9/11 with diagnoses hydration status and risk for including, but not limited to Left femur fracture dehydration with appropriate and Urinary tract infection. interventions implemented based on the assessment. Nurses Notes included the following notations: Themeasures or systematic changes that have been put 11/9/11 at 5:30 P.M.: "Admitted to [room into place toensure that the number]...Occ [occasionally] forgetful...Incont alleged deficient practice does [incontinent] of bladder uses briefs, not recur include: dribbles...needs assist for set up of oral care, HydrationRe-Assessments have meals. Assist [two] transfer...." been completed on all residents. The assessment will be A "Hydration Status Assessment," dated 11/9/11, completed on admission, indicated the resident had decreased food & fluid quarterly, if a resident returns intake, dry skin & mucous membranes, and from the hospital, or has a functional impairments. The assessment indicated significant change in condition. the resident was not on a diuretic, had no renal Based on the assessment. impairment or edema, was not lethargic, had no appropriate interventions will be abnormal lab results of electrolyte imbalance, and implemented as indicated for had no increased fluid needs. The resident's total each resident. The plans of care score on the assessment was 3 ["If 8 or above, MD have been updated toreflect any to be notified & hydration management needed interventions based on

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155773		LDING		01/31/	2012
		1 11 1	B. WIN				
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
					CDOWELL RD		
TERRAC	E AT SOLARBRO	N THE		EVANS	SVILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	interventions follo	wed"].			the assessment finds. The		
					Registered Dietician has		
	An Interdisciplinar	ry Care Plan, dated 11/9/11,			reviewed all residents in the		
	indicated, "Residen	nt diagnosed with UTI [urinary			facility and updated, if applica		
	tract infection]." A	pproaches included: "Offer and			recommended fluid requireme	nts.	
	encourage intake of	f fluids"			The Registered Dietitian will		
					review residents on a quarterl	y	
	Nurses Notes cont	inued:			basis orif there is a change in		
					resident status. Based on the		
	11/10/11 at 2:00 P	.M.: "Res [resident] will			Registered Dietitian's		
	respond weakly to	questions, takes sips H2O			recommendations, they dietar	у	
	[water] [with] assis	st. Required to be fed for meals,			fluid needs have been		
	takes few bitesIn	continent of urine x 4"			posted/updated to reflect that		
					most of the residents fluid intakesare served in accordar	.00	
	11/11/11 at 6:30 A	M.: "Incontinent of bladder,			with the resident's meals. In	ice	
	denies pain or burn	ning upon urination. Cont			addition, a hydration cart has		
	[continues] on AT	B [antibiotic] for UTI [urinary			been implemented that is		
	tract infection]Re	es does c/o [complain of]			provided X3 daily that will offe	r	
	frequency"				additional fluids to residents	'	
					including those on thickened		
	11/11/11 at 1:00 P	.M.: "Call out to [name of			liquids. Nursing, Dietary and		
	physician] office r	t [related to] pain			Activities staff have been		
	medicationPt [pa	tient] noted to be lethargic			in-serviced relating to offering	of	
	when taking[No]	NO's [new orders] @ this			hydration to residents.		
	time."				Thecorrective actions taken	to	
					monitor performance to ass	ure	
		.M.: "Remains on ATB for			compliancethrough quality		
	UTITaking fluid	s well [with] encouragement et			assurance is: A Performance		
		[sic] pt while eating. Continues			Improvement Tool has been		
	to c/o lethargy et v	veakness"			established that will randomly		
					review 5 residents to ensure the		
	11/11/11 at 5:00 P	.M.: "Pt c/o nausea earlier"			services are being provided in		
					accordancewith the physician		
		.M.: "Remains on ATB for			order and the written plan of c	are	
		f urinary frequency, no pain or			related to hydration. This tool		
	burning with urina	tion"			includes the monitoring of fluid	ds	
					provided via meals, hydration		
		.M.: "Taking fluids [without]			carts, the plan of care, the inta		
		ged to eat when offered. Pt			records, if applicable, based of		
	takes bites only."				the residents' assessment of t		
					at high risk or as been identific	ed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155773	A. BUI			01/31/	/2012
			B. WIN		ADDRESS COMMUNICATE STREET, CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					CDOWELL RD		
TERRAC	E AT SOLARBRON	NTHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	11/13/11 at 5:00 A.	M.: "ATB for UTIfluids			as having a Urinary Tract		
	encouraged [and] w				Infection. This tool will be		
					completed by the Director of		
	11/14/11 at 2:00 P.I	M.: "N.O. received for			Nursing, or designee,		
		c] et Lasix [diuretic]Res c/o			weeklyX3,monthlyX3, then		
	some nausea"				quarterlyX3. Any issues identif	fied	
					will be corrected immediately.		
	11/14/11 at 9:15 P I	M.: "Offered water at this time,			The completed audits will be		
	drank well with encouragement. Denied need to				reviewed at routinely schedule	ed	
	use bathroom"	2			Quality Assurance meetings w		
					additional recommendations a		
	An Interdisciplinary	Care Plan, dated 11/14/11,			needed. Residents identified a	IS	
		t at risk for fluid volume deficit			"at high risk" or having a UTI		
		rretic Use." Approaches			which requires daily intake/out		
		and report to physician signs			shift monitoring, will be review	ed	
		ehydrationPhysical signs &			daily by the IDT.		
		ration. Discuss with resident					
		fluid intake. Encourage fluid					
		ween meals. Observe for S/S					
		ns] of dehydration & report to					
		s, Dry mucous membranes,					
	_	turgor, Dark urine, Poor fluid					
	intake/thirstIncrea						
	mtake/timstmerea	isca comusion					
	A Nutrition Rick As	ssessment, dated 11/15/11,					
		rder, Mech [mechanical] soft					
		neatEating ability: Needs					
	1 20 10 2	Assist/CueingAverage fluid					
		onal Needs EstimationFluid					
	Needs (mL): 1590 r						
	1100d3 (IIIE). 1370 I	III					
	An additional Interd	disciplinary Care Plan, dated					
		, "Potential for alteration in					
		sis: [Left] femur fx [fracture]					
	1	and] pneumonia." Approaches					
	included: "Monitor						
	meradea. Widintol	1000, Huid Hitake.					
	Nurses Notes contin	nued:					
	1.01505 1.0005 001111						
	11/15/11 at 4:30 A	M.: "Refused to get up to the					
		d bedpan x 2Continues on					

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	OF CORRECTION IDENTIFICATION NUMBER: 155773	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2012			
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 MCDOWELL RD EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION			
	ATB for UTI" 11/16/11 at 4:15 A.M.: "Has been Inc x 1 this shift. Refused to get up [and] go to Bathroom. Has not used bedpanHas drank plenty of fluids" 11/17/11 at 1:30 P.M.: "Taking fluids well [with] encouragement" A Nutritional Progress Note, dated 11/17/11 at 9:00 A.M., indicated, "Residents [sic] wt [weight] 11/16/11 was 109 lbs, [down] 7 lbs x 1 wk [week]. Wt loss likely d/t [due to] both poor intake [and] some fluid loss d/t edema getting better from fx [and] repairIntakes seem to be improving slightly" Nurses Notes continued: 11/18/11 at 4:00 P.M.: "Pt remains weak. Not taking much nutrition. Encouraging med pass and magic cup when does not eatIncont of Bowel [and] bladder. Wears briefs" 11/18/11 at 7:30 P.M.: "Called to pt room. Had large incontinent stoolAbd [abdomen] distended, hard knot notedNew order need to transport to [name of hospital] ER [emergency room] for evaluation if family wishes." The resident was transferred to the hospital on 11/18/11 at 7:50 P.M. A hospital emergency room note, dated 11/18/11 at 10:59 P.M., indicated, "The patient was evaluated shortly after arrivalShe is very weak and dehydrated in appearance with dry oropharynx findingsShe does have a panic values sodium level of 118. She was started on some IV						
	fluidsFinal Impression, Abdominal pain, acute urinary retention, Altered mental status,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/31/2012		
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE			17	701 M	DDRESS, CITY, STATE, ZIP CODE CDOWELL RD VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	hyponatremia [low potassium]"	sodium], hypokalemia [low					
	REGULATORY OR LSC IDENTIFYING INFORMATION) hyponatremia [low sodium], hypokalemia [low						
	during a day. On 1/31/12 at 10:3	0 A.M., during interview with					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUI	LDING	00	COMPL	
155773		B. WIN	G		01/31/	2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF PROVIDER OR SUPPLIER				1701 M	CDOWELL RD		
TERRACE AT SOLARBRON THE				EVANS'	VILLE, IN 47712		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECT			
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	the Administrator, s	he indicated the family of					
		vith the resident frequently,					
		d not let staff wake the					
		or give her fluids. The					
	Administrator indicated the staff should have						
	documented that fac	t more thoroughly in the chart.					
	On 1/21/12 -4 0:25	A M the MDS Condition					
		A.M., the MDS Coordinator tacility policy on "Hydration					
	_	ted. The policy included:					
		e that all residents are assessed					
		and encouraged to consume					
	enough fluids to ens	e e					
		on will be maintained by					
		hrough meal service, juice					
	*	-					
	and/or water given with administration of medication, replenishing water bottles, and						
		ter throughout the day.					
		be at risk for dehydration are:					
		ght loss of 3 pounds or more in					
	one month. Residen	ts with dry skin and mucous					
	membranes. Resider	nts on diureticsResidents					
	with electrolyte imb	alanceResidents with					
	lethargy. Residents with fluid loss and increased						
	fluid needs (e.ginfection). Residents with						
	functional impairments (e.g. decreased mobility,						
	ambulate with 2 assist, bed bound). Residents with						
		nsLicensed personnel are					
	responsible for monitoring residents for signs and						
	symptoms of dehydration and for notifying the physician if symptoms occurPlace water bottles						
		ourage residents to drink staff will monitor all residents					
		tion (ex: dry mouth, nausea,					
		ent hydration interventions and					
	notify the physician						
		nsIdentify and offer resident					
		vide extra fluids with UTI					
		on]/feverBeverage easy					
	access."						

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	OF CORRECTION	IDENTIFICATION NUMBER: 155773	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	LETED /2012
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE			1701 M	ADDRESS, CITY, STATE, ZIP CDOWELL RD SVILLE, IN 47712	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	This federal tag related 3.1-46(b)	ates to Complaint IN00102912.				

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